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ABSTRACT

This report summarizes the activities of a forum held by the Healthy Mothers, Healthy Babies (HMHB) Coalition on maternal and child health issues affecting communities of color. Participants highlighted their communities' problems related to infant and child health, identified critical issues that need to be addressed from each community's perspective, proposed broad-based strategies to address the problems, and made recommendations. Individual sections address the needs and concerns of the African-American, Asian and Pacific Islander, Hispanic/Latino, and Native American communities. The report recommends that: (1) the health care system must recognize and respect cultural diversity by including diverse community representatives at national, state and local levels; (2) methods of data collection and analysis need to be revised to accurately assess the health problems of communities of color; (3) the health care system must shift its medical focus away from the disease model to promotion of health and wellness models; (4) more resources must be made available to continue and expand the roundtable process; (5) communities of color need national representation by organizations willing to advocate on their behalf; and (6) organizations of color need to be supported by mainstream national organizations. Two appendices provide a directory of model maternal and child health programs and a list of HMHB staff and organizational members. (MDM)

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A Report on Healthy Mothers, Healthy Babies
Communities of Color Leadership Roundtable

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ACKNOWLEDGEMENTS

The Healthy Mothers, Healthy Babies Coalition (HMHB) would like to recognize and express its sincere thanks to the organizations that supported Unity Through Diversity: The Communities of Color Leadership Roundtable. Our thanks go to Metropolitan Life Foundation, whose visionary support enabled HMHB to launch the Initiative, and to the MetPath Foundation, the federal Maternal and Child Health Bureau, the Office of Minority Health, the Health Care Financing Administration, and the American College of Obstetricians and Gynecologists for their support of the Roundtable.

Unity Through Diversity

A Report on the Healthy Mothers, Healthy Babies Coalition
Communities of Color Leadership Roundtable

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August 1993

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Dear Colleagues,

The national Healthy Mothers, Healthy Babies Coalition (HMHB) hopes that you will use this report to broaden your understanding of the maternal and child health issues faced by communities of color. Health care professionals and community activists alike can use it to participate in the efforts needed to improve birth outcomes and child health within communities of color across the nation.

Here are some suggestions that will help us to reach that goal:

- Recognize the impact of changing demographics;
- Acknowledge and respond to the need for the development of political will and commitment to effect change;
- Seize every opportunity to advocate for increased funding for maternal and child health;
- Make sure organizations established to serve communities reflect the communities being served;
- Look at your own organizations in terms of whether they are culturally competent and can serve as role models for community and affiliate organizations;
- Establish recruitment and career development programs to increase the numbers of people of color in decision-making positions within maternal and child health (MCH) organizations;
- Provide diversity training for managers and volunteer staff of MCH organizations;
- Help to provide arenas, such as community forums, where communities of color can have a collective voice, and develop task forces to address specific issues; and
- Develop a research agenda around maternal and child health issues within communities of color.

As we begin to truly understand the issues facing our communities of color, the next step is to take action. We cannot choose to be silent or inactive about the issues facing these communities and still hope to make a difference in our nations birth outcomes. We invite you to work with us to move forward in creating inclusive solutions.

Sincerely,

Jan Chapin
Chairperson

Claudia Morris
Director, Initiative for
Communities of Color

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The Healthy Mothers, Healthy Babies Coalition (HMHB) is made up of more than one hundred national, professional, voluntary, and governmental organizations with a common interest in maternal and infant health. The purpose of the Coalition is to foster educational efforts for pregnant women and new mothers, and their families, through collaborative activities and sharing of information and resources. Its goals are to:

- **Promote** public awareness and education in preventive health habits for all pregnant women and their families;
- **Develop** networks for sharing information among groups concerned about improving the health of mothers and babies;
- **Distribute** public education materials on topics related to improving maternal and child health (MCH); and
- **Assist** the development of state Healthy Mothers, Healthy Babies coalitions.

HMHB's Minority Outreach Initiative, funded by a grant from Metropolitan Life Foundation, became active in August 1991. It was conceived in response to the urgent need to gain ground in the battle to reduce infant morbidity, mortality, and low birth weight in communities of color across the United States. Through the Initiative, HMHB is committed to bringing the voices of communities of color to the table, listening to issues related to maternal and child health as defined by them, developing a mechanism to include maternal and child health leaders from these communities in federal and state planning processes on a consistent basis, supporting and working in collaboration with organizations that represent communities of color, and providing a model for other national MCH organizations to become culturally competent.

Unity Through Diversity: the Communities of Color Leadership Roundtable was planned and carried out under the direction of the HMHB Minority Outreach Initiative. Both it and this resulting publication, *Unity Through Diversity*, are the first steps in our efforts to become more responsive to communities of color.

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Despite more spending per capita on health care in the United States than in any other nation, our health care system is failing to serve, effectively, many of the nation's communities. In particular it is all too often insensitive and ineffectual in meeting the health needs of communities of color. Perhaps no amount of money could fix those problems; instead, the critical needs of those communities, as they are self articulated, must be addressed. As the composition of the United States changes, communities of color are experiencing steady growth at the same time that they face worsening health problems.

By now it is well recognized that the United States ranks twenty-second behind other industrialized nations in the number of infants who die before the age of one year—but less so that a disproportionate amount of those deaths occur among infants of color. Although progress in reducing our infant mortality rate has continued for decades, the rate of decline slowed in the 1980s and the disparity between rates for whites and those for communities of color, when they are known, has persisted; the mortality rate for African American infants remains about twice as high as that for white infants.

The risk of maternal deaths, which result from complications of pregnancy, childbirth, or the postpartum period, is more than three times greater for African American women and 50% greater for other women of color than for white women. Low birth weight, with its attendant risk of infant mortality or long term disabilities, occurs much more frequently in communities of color than in white communities.*

The issues and concerns of communities of color all too often go unrecognized when programs and services for them are being planned. Additionally, the available knowledge about these communities is grossly generalized.

Unity Through Diversity: the Communities of Color Leadership Roundtable, marked a dramatic first step in HMHB's efforts to provide a forum for communities of color to come together to discuss issues of maternal and child health from their perspectives. On June 17, 1992, the HMHB's Minority Outreach Initiative brought together 20 leaders active in successful efforts to promote maternal and child health in their communities. The participants represented four broad communities of color: the African American, Asian and Pacific Islander, Hispanic/Latino, and Native American communities.

Initially, HMHB responded to the same critical situation which necessitated its Minority Outreach Initiative—the infant mortality rate and other worsening health indicators in communities of color—by proposing to develop a directory of model programs highlighting successful strategies for health promotion and infant mortality reduction in those communities. After serious discussion and thought among HMHB Board members and staff, however, it became clear that more was needed to effect real change. This led to plans to convene the Communities of Color Leadership Roundtable which was given the theme, Unity Through Diversity.

Objectives for the Roundtable were twofold: 1)to provide a forum for representatives from communities of color to bring their issues and concerns to the table and be heard;

* Low birth weight is defined as a birth weight of less than 2500 g in any newborn, regardless of gestational age.

and 2)to provide HMHB members and state coalitions with direction and strategies to work more effectively within communities of color.

Unity Through Diversity was successful at fulfilling both objectives. The roundtable approach encouraged an environment in which women and men who are sensitive to the issues of those communities most affected by infant mortality, low birth weight, poor child health, and numerous other health, social, and economic problems could meet and have a meaningful exchange.

Participants highlighted their communities' problems of infant and child health, identified critical issues that need to be addressed from each community's perspective, proposed broad-based strategies to address the problems, and made recommendations to HMHB and the mainstream maternal and child health community. The resulting perspective is one that acknowledges both cultural diversity and commonalities, fosters community empowerment, and supports the development of culturally competent service delivery systems.*

The message of the Roundtable participants was clear: The existing health care system is not meeting the needs of communities of color and must be significantly changed. Some of the common deficiencies perceived by all groups include racism and cultural insensitivity, an overemphasis on the disease model of medical care and neglect of health and wellness concepts, an absence of accurate data collection and analysis, a shortage of needed resources, a crucial need for community empowerment and outreach, and a glaring need for appropriate, culturally sensitive training for health professionals.

Six major changes in the system have been proposed:

1. Our health care system must become one that recognizes and respects cultural diversity and provides culturally competent services that are community-based.

2. Current methods of data collection and analysis must be assessed and revised to accurately capture problems of maternal, infant, and child health in communities of color.

3. Our existing health care system must shift its medical focus away from the disease model to promotion of health and wellness models of care with respect for traditional health practices.

4. More resources must be made available to expand and continue the Roundtable process and begin developing policy to effect change.

5. Communities of color, all but disenfranchised by the current system, need national representation by organizations willing and able to advocate on their behalf for program and policy expansion.

6. Organizations serving people of color need to be supported by mainstream national organizations in their efforts to develop linkages with one another and build collective support to effect change.

*A definition of a "culturally competent" system of care has been provided by Terry L. Cross, Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs, in their monograph, *Towards A Culturally Competent System of Care* (Washington, DC: Child and Adolescent Service System Program, National Institute of Mental Health, 1989). They describe such a system as one that "acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs."

The valuable lessons that were learned from the Roundtable are shared in this publication in greater detail. It is hoped these will be read widely within the maternal and child health community and used as a resource in developing community-based systems of care, ones that will make a difference in birth outcomes and child health within communities of color. A selective directory of successful maternal and child health programs in communities of color has been included at the end; many of these exemplify strategies highlighted by the Roundtable participants.

While welcoming the opportunity to share information and strategies and to be heard by HMHB, the participants urged that the Roundtable be viewed as just the beginning of a process that should be continued and expanded. It must be repeated again and again with communities of color across the nation until the process of inclusion defines the standard for developing health policy and health care systems, and must go beyond discussing the issues to collaborating on solutions.

The Year 2000 is fast approaching, and the prospect of reaching the nation's health goals proclaimed in Healthy People 2000, which include reducing infant morbidity and mortality in all of our nation's communities, is becoming increasingly remote. The urgency of eventually reaching those goals, coupled with our knowledge of communities of color as a rapidly growing component of the U.S. population, make it imperative that the maternal and child health community follow a course that is responsive to *all* communities.

The questions we must ask ourselves as health care professionals are: Where do the issues facing communities of color fit into the larger picture with respect to maternal and child health programs developed at a national, state, or local level? How can we begin to incorporate these issues more effectively?

In the aftermath of Unity Through Diversity: the Communities of Color Leadership Roundtable, HMHB has emerged with a process that can be replicated to demonstrate the impact which communities of color can have when they come together to solve their own problems. The Roundtable itself is a valuable resource, one that can serve to provide answers to the crucial health questions facing our communities of color. In doing so, it affirms the importance of promoting diversity in fulfilling human potential.

Unity Through Diversity: the Communities of Color Leadership Roundtable brought together a unique group of women and men representing four distinct communities of color: African Americans, Asians and Pacific Islanders, Hispanic/Latinos, and Native Americans. Together the participants embodied considerable professional expertise in maternal and child health as well as a shared commitment to improving the quality of care and services to mothers and children in all their communities. All are dedicated to political activism within the maternal and child health community and greater communities.

Nominations for the Roundtable were solicited from HMHB member organizations and various national, state, and local organizations that represent people of color. Of some 250 nominations, only 20 participants could be selected to participate. The choices were guided by HMHB's desire to formulate a mix of participants representing different races and ethnicity as well as a blend of national, state, and local experience, and who would bring to the Roundtable a variety of regional concerns.

CHARON ASETOYER, MA, is executive director of the Native American Women's Health Education Resource Center (NAWHERC) on the Yankton Sioux Reservation in Lake Andes, South Dakota. NAWHERC is the first organization to be located on a reservation providing health information, referral services and a resource center on education, economic development and land and water rights. Ms. Asetoyer develops health awareness and prevention programs on issues such as AIDS and fetal alcohol syndrome (FAS). She has written several articles on FAS and now is writing a book on its impact on indigenous populations.

Ms. Asetoyer

BYLLYE Y. AVERY, MED, is founding president of the National Black Women's Health Project in Atlanta, which is committed to defining, promoting, and maintaining the physical, mental and emotional well-being of African American women. Past recipient of the MacArthur Foundation Fellowship for Social Contribution and the Essence Award for Community Service, Ms. Avery has been a women's health care activist for 20 years.

Ms. Avery

JUDY A. BENTLEY, MBA, is executive director of Community Health-in-Partnership Services (CHIPS) in St. Louis, Missouri, an innovative health and social service organization providing assessments and managed referrals for an indigent population. Prior to designing the CHIPS program, Ms. Bentley had combined her skills as a medical records administrator, public health nurse, and certified nurse practitioner, by designing and implementing the first adolescent health program in St. Louis.

Ms. Bentley

ERNEST C. BIGHORN, JR, MA, is director of the Indian Development and Educational Alliance, Inc., in Miles City, Montana, which provides social, legal, health, and education services. Mr. Bighorn has provided personal, family, social, occupational, and educational counseling to Native Americans for over 20 years.

I. ANGELINA BORBON, RN, is project director of Sacred Circle of Birth, a community-based organization delivering perinatal services to the urban Native American community in Oakland, Calif. Ms. Borbon, a Mestiza Mexicana (Yaqui) from southern Arizona, has provided public health services to childbearing women and their families for over 20 years.

NGUYEN MINH CHAU, MA, EDS, MS, is executive vice president of Opportunity Systems, Inc., in Washington, DC. She also is president of the Organization of Pan Asian American Women, Inc. (Pan Asia), a national, multi-ethnic women's organization that advocates and encourages their participation in all aspects of American society. Ms. Chau works with community organizations across the country to increase opportunities for Asian Pacific women.

Ms. Borbon

Ms. Chau

Ms. Crawford

Ms. Ho

Ms. Holmes

GEORGIA CRAWFORD, BS, is executive director of the Navajo Nation Family Planning Corporation in Window Rock, Arizona. She currently serves on the board of the National Family Planning and Reproductive Health Association and is an appointee on the Governors Advisory Committee on Adolescent Pregnancy in New Mexico. Ms. Crawford has over fifteen years experience serving the health care needs of the Navajo community.

MAI-MAI QUON HO, MSW, ACSW, LCSW, is project coordinator for Asian Perinatal Advocates in San Francisco, an organization seeking the prevention of child abuse and neglect in Asian families. She also is a medical social worker at the San Francisco General Hospital, providing inpatient services in the newborn nursery, labor/delivery and postpartum ward. Ms. Ho has been active in family support training, child welfare, and parent education efforts.

LINDA JANET HOLMES, MPA, is responsible for developing injury prevention programs for the New Jersey Department of Health, Division of Family Health Service in Trenton. A consultant for the World Health Organization and former faculty member of the Nurse Midwife Educational Program at the

University of Medicine and Dentistry of New Jersey, Ms. Holmes is active with several women's health and birthing projects and has written extensively on birthing and midwifery issues since 1975.

THIDA KHUS is executive director of the Cambodian Network Council/Cambodian Network Development Project in Washington, DC. Ms. Khus has personal and professional experience working with the Cambodian American community in refugee resettlement, program design, organizational development and grants management, and has received numerous awards for her service.

LILLIAN S. LEW, MED, RD, is the project director of the Southeast Asian Health Project in Long Beach, Calif., where she directs four major health education programs serving Southeast Asians. The programs focus on: prenatal/maternal health support and cultural access, health education outreach, anti-tobacco education outreach, and parent outreach. Ms. Lew has published and presented extensively on such topics as understanding the Southeast Asian health consumer, women refugee issues, and the provision of culturally sensitive health care.

Ms. Khus

Ms. Pena

Dr. Raggio

Dr. Rocco

ALMA SHEPHERD PENA, MA, is the Healthy Mothers, Healthy Babies coordinator for the Arizona Department of Health Services. Arizona HMHB promotes public education to improve maternal and infant health, and has 14 member coalitions throughout the state, including those on Native American reservations. Ms. Pena has served as a manager of family and community programs, coalition builder for multicultural populations, community organizer, educator, and advocate for maternal and child health.

TANYA PAGAN RAGGIO, MD, is medical director for the Alma Illery Medical Center in Pittsburgh, Pennsylvania. She also is the Executive Director of the Pittsburgh Healthy Start Project. In the past she has been medical director for school districts in Pittsburgh and Wilkinsburg and for perinatal and teenage primary health care programs. She has provided medical consultation to health projects and health departments and has lectured extensively on minority and women's health and perinatal issues.

CARMEN DE LA CRUZ ROCCO, MD, is medical director for the Brownsville Community Health Center in Brownsville, Texas. She also is a clinical assistant professor of pediatrics at the University of Texas

Medical Branch at Galveston, and medical director of the Community Oriented Primary Care Program Association, Inc. (COPRIMA), also in Brownsville. Dr. Rocco has been active in promoting Hispanic medical education.

DIANE L. ROWLEY, MD, MPH, is deputy branch chief for Pregnancy and Infant Health within the Centers for Disease Control, Division of Reproductive Health. She has lead responsibility within her division for coordinating and conducting infant morbidity and mortality studies and providing technical assistance to the states. Dr. Rowley has published and lectured on infant mortality, low birth weight, African American women's health issues, and race and racism as health determinants.

JESUS JOSE (JOE) RUBIO, JR, PHD, is the national director of Chapter Program Services for the March of Dimes Birth Defects Foundation in White Plains, New York. He provides training and technical assistance to 131 March of Dimes chapters to achieve community-based, volunteer programs, and is responsible for national initiatives such as Healthy Start and programs focused on priority populations. In the past,

Dr. Rowley

Dr. Rubio

Ms. Thomas

Dr. Rubio has been founder of community-based initiatives to address prenatal care, access to care, teenage pregnancy and maternal and child health issues. He is active in numerous community and MCH organizations.

CYNTHIA A. SMITH, MPA, is executive director of Northern Plains Healthy Start and assistant professor of Community Medicine and Rural Health at the University of North Dakota School of Medicine in Grand Forks, North Dakota. Northern Plains Healthy Start, representing 17 tribes in four states, seeks to reduce the infant mortality rate among Native Americans by one-half. It is the only Native American demonstration project among the 15 national Healthy Start projects. Ms. Smith has been active in the provision of technical assistance, health staffing, and tribal health planning to rural communities.

JOYCE N. THOMAS, RN, MPH, PNP, is president and co-founder of the Center for Child Protection and Family Support, Inc, in Washington, DC. Former director of the Division of Child Protection at Children's Hospital National Medical Center, Ms. Thomas is a nationally and internationally recognized expert on cultural competency and ethnic minority concerns in the field of victimization.

HO LUONG TRAN, MD, is an intervention specialist for the Illinois Department of Public Health and the Centers for Disease Control, working to reduce morbidity from cervical cancer in high-risk populations in Chicago. Formerly an attending physician in pediatrics at the Nguyen Van Hoc General Hospital in Saigon, Dr. Tran has been actively involved in immigrant refugee issues.

HENRIETTA VILLAESCUSA, BSN, RN, is executive director of Villaescusa Enterprises in Los Angeles, where she provides technical advice and consultation in areas such as public health administration, health planning and analysis, community health planning, consumerism, community development, citizen participation, and health system design, implementation and evaluation. Ms. Villaescusa has publicly served the Offices of Maternal and Child Health and of Economic Opportunity, the Health Services Administration, and the Agency for International Development, and has consulted privately for over 60 professional and community organizations.

Dr. Tran

Ms. Villaescusa

Dr. Villareal

SYLVIA FERNANDEZ VILLAREAL, MD, is director of the Early Childhood Service and Kempe High Risk Clinic at San Francisco General Hospital, and assistant clinical professor of pediatrics at the University of California in San Francisco. The Kempe Clinic serves teen mothers and their children, chemically exposed infants and their mothers, and children who fail to thrive. Formerly both a W.K. Kellogg National Fellow and Robert Wood Johnson Scholar, Dr. Villareal has concentrated on child health policy for poor and minority communities.

In convening Unity Through Diversity: the Communities of Color Leadership Roundtable, it was important to HMHB that the concerns each group brought to the Roundtable be understood and respected. The agenda and the process for the Roundtable reflected these sensitivities.

Early in the project, it became clear that the scope of the Roundtable had to be broadened beyond infant mortality. Initially, the scope of the problem was defined according to the status of infant health within each of the four representative communities of color. Within the Hispanic/Latino and the Asian and Pacific Islander communities, however, infant health is often not the major problem. Participants from those communities revealed that indicators of child and adolescent health, such as morbidity from measles and other diseases, teen pregnancy, lack of early prenatal care, and more, reflect a truer picture of the status of health in their communities. As a result, the scope of the Roundtable was broadened to include not only infant, but also child health.

In preparation for the one-day Roundtable, background material and a list of discussion points were sent to each participant. The discussion points asked them to describe the scope of the infant and child health problems in their communities, identify key issues and barriers related to the those problems, describe strategies that work to assure healthy babies in their communities, and recommend how HMHB can support communities of color in efforts to reduce the incidence of infant mortality and morbidity, low birth weight, and poor child health.

Initially, in planning the Roundtable, HMHB hoped to bypass detailed discussions of the problems of infant and child health in each of the communities represented and to concentrate instead on effective service delivery strategies and other solutions. However, while the Roundtable process was not new for most of the participants, it was the first time many had participated in such a culturally diverse group. As a result, defining the problems from the point of view of each of the participants became a necessary first step. It served to familiarize the participants with the problems faced by other communities of color, opened a dialogue to identify common issues and concerns, and forged the beginning of a productive work group relationship.

Following introductions, participants broke into four separate work groups during the morning session, one for each community represented. Each group was asked to address the series of discussion points (described above) as they pertained to their community. During the afternoon session each work group reported back to the entire Roundtable. The final item on the agenda was a discussion of crossover issues among the four work groups.

The discussions that occurred in the separate work groups are highlighted within this report. There is an overview of the leading maternal, infant, and child health problems as presented by each community of color, as well as the key points of discussion that took place in each work group and any specific recom-

mendations that were made. While certain themes identified within each of the four work groups have much in common, it is important to remember that each group had its own particular analysis based on its history and experience in this country. Therefore, as a means of respecting the autonomy of each group, common issues have been presented as unique concerns. The reader may note some overlap.

Also included is a summary of the afternoon discussion held by the entire group in which crossover issues were recognized. This discussion formed the basis for the six major changes that are described in the Executive Summary and at the end of this report.

There are additional factors to keep in mind when reading this report. First, while Roundtable participants were encouraged to express their views fully and frankly, their discussions by no means represent all issues and concerns that have an impact on their respective communities of color. Rather, they reflect the interests and emphases of the individuals taking part in the Roundtable.

Finally, this report represents only the beginning of a process to develop policies that are inclusive of all communities of color. The participants look forward to much additional work, including further discussion, research, and other coalition-building activity to build a health care system that will adequately meet the needs of the many communities of infants, children, and families in our nation.

COMMUNITIES OF COLOR

A CULTURALLY DIVERSE AND EMERGING MAJORITY

It has been projected that by end of the twenty-first century, no one racial or ethnic group will comprise a majority in the United States (1). People of color will be the majority in 53 of America's largest cities by the year 2000, when one out of every three Americans will be either African American, Asian/Pacific Islander, Middle Eastern, or Hispanic/Latino. By the year 2030, experts predict that people of color will make up more than half of the U.S. population (2).

The reality of cultural diversity in the United States, coupled with poor health status in many communities of color, has far-reaching economic, political and social ramifications. These ramifications demand a commitment from our leaders at all levels to address and take action on the issues raised by these communities with respect to their health and well being. Currently they struggle with problems such as infant mortality, morbidity, low birth weight, and poor child health status. Current statistics on these health indicators within communities of color provide a telling picture of the future of our nations health.

For example, although the mortality rate for U.S. infants dropped from 29.2 per one thousand live births (29.2/1000) to 9.8/1000 between 1950–89, striking racial and ethnic disparities still exist. In particular, there are significant differences between the mortality rate for African American babies (18.6/1000 in 1989), Native American babies (13.5/1000 for the period 1984–86), and white babies (8.1/1000 in 1989) (3). The low birth weight rate for Asian Pacific Islanders is slightly higher than the rate for white Americans; significantly, however, there are insufficient data to determine how severe the problems of mortality, morbidity and low birth weight are among the subpopulations of this group.* The statistics for Hispanic/Latino communities reflect similar gaps in datarevealing high postneonatal mortality,** low birth weight, and high infant mortality among the Puerto Rican community.

Recent studies suggest that we must look beyond health status and address the causes of racial and ethnic disparity and other historical and psychosocial issues as well (4). The causes of these sobering health indicators are much more complex than simply lack of access to services. Each of these communities has had a unique experience in a larger culture which views them as minorities.

It is also important to note that communities of color should not be defined only by their problems. Inherent within each culture is a wonderfully distinct complexity and rich diversity.

*Subpopulation refers to an indentifiable fraction or subdivision of a population (ie, the Vietnamese are a subpopulation of Asians).

**Postneonatal mortality refers to the death of an infant after the first month of life.

Roundtable participants acknowledged shared strengths and strategies for survival, consisting of the following elements within each of the four communities of color represented.

- Each community is rooted in cultures that respect the earth and our responsibility as human beings to live in harmony with all nature;
- Each community developed from cultures with a deep respect for the divinity and inher ent dignity of each human being;
- Each community has cultural traditions of and holistic healing which demonstrate a respect for the person and his/her ability to heal him/herself and return to a natural state of balance and homeostasis; and
- Each community has been transplanted, albeit by different means, to a nation which systematically rejects these notions. (Even Native Americans have been transplanted in the sense that they have been torn from their tribal homelands and moved onto reservations or into communities in which they are viewed as "the other.")

Work group participants included Byllye Avery, MEd, as group leader, Judy Bentley, MBA, Linda Holmes, MPA, Alma Pena, MA, and Joyce Thomas, RN, MPH, PNP.

Overview

Infant mortality among African Americans, at more than twice the rate of that for white Americans, is unacceptably high. Their incidence of low birth weight follows a similar trend, affecting 13.5 percent of births to African American women versus 5.7 percent of births to white women in 1989 (5). Despite the steady decrease in rates for both groups over the past three decades, the documented gap in infant morbidity and mortality rates for the two communities has remained virtually unchanged. The largest community of color represented at the Roundtable, African Americans account for 12.1 percent of the U.S. population.

The African American work group attributed poor birth outcomes for African American women to such factors as high rates of teenage pregnancy, lack of early prenatal care, smoking, diabetes, and maternal alcohol and drug abuse. The group recognized that disparities in health status will not diminish unless maternal and child health care systems begin to look beyond the surface and address socioeconomic factors and psychosocial issues associated with the African American community that lead to high-risk health conditions and behaviors. The group views community and political empowerment as the paramount strategy to address these underlying problems; such empowerment can be achieved through greater use and funding of community-based organizations for delivering health care, an increase in African American providers, and an emphasis on cultural competency both in the organizations that deliver health care and in the maternal and child health leadership structure.

Points of Discussion

Racism. It was the consensus of the African American work group that racism remains a part of the fabric of American society and that it pervades every major institution, including churches, schools, courts, prisons, and health care facilities. Racism has had a particular impact on the health care system, in the view of the group, and has significantly reduced African Americans' access to care (ie, the availability, accessibility, and acceptability of services), and medical education. Perhaps as a result, health statistics reflect that the African American community as a whole has poorer health status than that of white Americans. This makes the development of culturally competent systems of care all the more necessary.

To combat racism and cultural insensitivity within the health care system as a whole, the group called for the development of culturally competent systems of care (refer to Executive Summary for definition). The group also called for the development of core curricula about African American culture in the training of

health care professionals. These would address real cultural differences and help combat myths and stereotypes which interfere with understanding and acceptance. The strengths and contributions of African American people and communities should be stressed.

RECOMMENDATION: *Develop culturally competent systems of care for the African American community and core curricula that emphasize African American culture for health care providers.*

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Another problem is that the number of African Americans who have received a medical or allied health education is low in relationship to the health care needs of the African American community as a whole. One reason may be that the health care industry and media have given limited exposure to African American professionals, resulting in few role models available to influence the professional choices of African American students. Also, African American health professionals often have difficulty securing financing for their education.

Those African Americans who do become trained as health professionals do not always return to the community. The burden of loan repayments makes lower paying community service positions less attractive.

Mentoring, Upward

Bound and career development programs should be supported as necessary parts of identifying, encouraging, and enabling African American youths and adults to become health care professionals; in addition, they need better understanding of and greater access to the U.S. Public Health Services National Health Service Corps.

Finally, increased numbers of African Americans need to be recruited as managers of community-based organizations and provided with ongoing support in the form of technical assistance, career development, and networking opportunities. Budget constraints make it difficult for them to develop the necessary expertise in areas such as fundraising and development; therefore rarely do they advance into the upper echelons of maternal and child health organizations. A combination of men-

toring, executive appointment and other programs is necessary to break the glass ceiling and increase the number of African Americans in higher salary groups and volunteer leadership positions.

Recruit and develop ongoing support mechanisms for African American program managers to supply them with technical assistance and career development opportunities.

Community and Political Empowerment. Group participants felt strongly that the collective voice of the African American community has yet to be heard in terms of maternal and child health issues. African Americans are, for the most part, not involved in the formal problem-solving process; historically, they have not been represented by those organizations invited to the table where policy decisions are made. As a result, African Americans lack the power and resources to effect broad-based changes, both in their own communities and on a national level.

Despite this, African Americans are acutely aware of the pressing health care needs in their communities and, more important, what strategies work and do not work. Therefore, as a first step towards change,the group called for empowerment and self-determination among African Americans, allowing them to develop solutions to heal their own communities.

How are maternal and child health services to be designed so that communities and individual clients are given a sense of empowerment? There was particular agreement within the group about the fact that more community-based health centers are needed, that such centers are the answer to delivering services in a manner that doesn't intimidate clients and does reinforce their sense of self-worth. The political pressure for such centers can be generated by African American medical societies and professional organizations.

Seek support within the African American leadership structure for community-based organizations providing culturally-appropriate services to the African American community.

Unfortunately, community-based organizations face major funding challenges to establish innovative programs and to maintain successful programs once they are up and running. Small organizations have staffing constraints which often preclude the development of in-house expertise; this makes it difficult for them to identify funding sources and develop successful grant proposals. The lack of technical expertise also has a major impact, as do government restrictions such as time-limited grants and the labor-intensive processes involved in submitting grant applications.

Increase funding, extend funding periods, and offer technical assistance for community-based primary care services in programs with established track records of providing culturally competent services to communities of color.

Outreach. Some maternal and child health organizations have limited the status and effectiveness of African American community outreach workers, who are frequently employed in low-paying positions with limited responsibility and virtually no advancement to management

levels. Often they are supervised by mainstream professionals with little knowledge of outreach methods that are effective in African American communities.

Recognize and validate the crucial role of community outreach within community-based maternal and child health organizations.

Access Issues. The group felt that primary health care services to mothers and infants must be extended beyond the first six weeks or five years of life, as is current practice. Mothers and infants need to be followed after their release from the hospital or birthing center. Children need to be assured of care throughout their growth, and into adulthood, at least through the first 20 years of life.

Extend coverage of primary health care services beyond infancy or early childhood into young adulthood.

The group labeled midwifery services and freestanding birthing centers as vital alternatives to hospital-based obstetric care from physicians. Midwifery provides a supportive environment that promotes the concept of wellness among women and their role in the birthing process. In some communities, however, midwifery services have met with opposition from the medical community; in others, the scope of services which midwives are allowed to perform is limited. Moreover, there is a shortage of available midwifery services in the African American community. Particularly in urban and rural settings with little or no access to physicians, these alternatives should be used.

Increase education about midwifery and free-standing birthing centers as valid alternative obstetric approaches.

Behavioral and Environmental Factors. The group felt that behavior and environment (eg, alcohol and drug abuse, and violence) and their effect upon the mortality and morbidity of African Americans are not sufficiently addressed by the maternal and child health community. The needs of the community cannot be isolated from the environment in which services are delivered and the effects of that environment upon its inhabitants.

Another critical issue identified by the group was the inability or unwillingness on the part of health professionals to address the gender-specific issues of African American women, ie, their relationships with significant others and with their children, and their child care needs.

Data Collection. The group called for self-determination in the design of data collection within the African American community. Not only is there a lack of data with respect to how subpopulations within the African American community (eg, persons from Haiti, the Caribbean and Central America) differ in terms of health practices, beliefs, and concomitant service needs, but researchers' lack of familiarity with the norms and culture of the African American community calls into question much of the data that have been collected.

Work group participants included Nguyen Minh Chau, MA, Ed.S., MS, as group leader, Mai-Mai Quon Ho, MSW, ACSW, LCSW, Thula Khuo, Lillian Low, MEd, RD, and Ho Luong Tran, MD.

Overview

Asian and Pacific Islander populations account for 2.9 percent of the U.S. population. They appear to have the nation's lowest infant mortality rates, ranging from 4.0 per one thousand live births (4.0/1000) among Japanese Americans in 1986 to 6.5/1000 among Asians other than Chinese, Japanese or Filipino. These rates compare with 8.9/1000 among white Americans and 10.4/1000 among the nation as a whole (6).

Because of these figures, many believe that the Asian and Pacific Islander community has no maternal and child health problems, but this misrepresents the facts. Rates of low birth weight differ among ethnic groups within the community, but overall are higher than those among white Americans. Asians have the highest proportional mortality due to birth defects. The scope of indicators to define infant and child health within this community must be broadened to other major health indicators besides infant mortality.

The impact of such factors as poverty, lack of medical insurance, young age at parity, low educational attainment, single mothers, and increasing alcohol and drug abuse in the community often go ignored. As a result, funders and planners of programs and services fail to consider all of this group's maternal and child health needs. There is a particularly high incidence of infant mortality and low birth weight associated with lower incomes and childbearing at a younger age. Refugee women lack knowledge of family planning services, and in some areas, Southeast Asian refugee women have prenatal care only in the third trimester. Southeast Asian refugee children show a higher prevalence of lead absorption than other high-risk groups.

The National Birth Cohort Study suggests that the underestimation of infant mortality rates for Asian and Pacific Islanders ranges from 28 percent for Chinese, to 39 percent for Japanese, to 51 percent for Filipinos, to 61 percent for other Asians (7).

Points of Discussion

Data Collection. Data on the Asian and Pacific Islander community do not account for its different subpopulations (eg, Vietnamese, Cambodians, Laotians, Hawaiians, Filipinos, Samoans, Guamanians, etc). Researchers also overlook differences within subgroups, such as acculturation and education,* even though

*Acculturation is defined as the cultural modification of an individual, group, or people, through prolonged and continuous interaction involving intercultural exchange and borrowing from different cultures. The term is often used when referring to second or third-generation immigrants as opposed to those who are newly arrived.

important distinctions exist between the American-born Asian group and new immigrants, whose needs and concerns are vastly different. As an example, American-born members of this community usually have mastered the English language and to a large extent have accepted the Western health care system. Foreign-born or new immigrants, on the other hand, often encounter a language barrier. Most of them come to the United States with traditional beliefs that may interfere with their seeking care, such as the belief that health status is predetermined by fate and therefore the individual need not be active in the health care process.

The tendency to lump together available data, coupled with the unavailability of data on certain subpopulations, are at least in part responsible for the myth of the Asian and Pacific Islander community as a healthy and economically successful model minority.

Cultural Issues. Asian and Pacific Islanders tend to keep problems to themselves and are hesitant to demand services. This cultural tendency makes it difficult to identify individuals who are in need. In addition, many Asians and Pacific Islanders continue to adhere to traditional health practices, such as the use of herbal medicines and ointments, and practices, including coining, a therapy consisting of rubbing an area of skin with a coin to bring heat back into the body. The lack of understanding and acceptance of these traditional remedies may also contribute to reluctance among clients in this community to expose themselves to Western health care practices.

Even when services are available to this community, cultural factors such as these may impede access and result in underutilization. Outreach and home visitation by trained staff could bring services closer to those members of the community who are at risk, and also help break through the cultural barriers which prevented clients from seeking care in the first place.

Increase access to programs and services through outreach and home visitation.

Community Involvement. Greater community involvement also can help in identifying real needs that lie behind these cultural and communications barriers; unfortunately, the historically low level of activism found within Asian/Pacific Islander communities has contributed to the misperception of Asians/Pacific Islanders as a model minority. There is a feeling among leaders of this community that strategies should be developed to empower it to articulate its issues and concerns more clearly and effectively, and to make sure that its requests for services get the attention they deserve. Representatives from the diverse segments of the Asian and Pacific Islander community should be actively recruited to participate in forums addressing maternal and child health issues; their input can help to clarify issues, put pressure on policy makers, educate the public, and facilitate increased funding. Coalition building should be undertaken at the local, state and national levels.

An effort should be made to actively recruit members of the Asian/Pacific Islander community to participate in maternal and child health forums and coalition-building at all levels.

Funding. The absence of refined data about this community, coupled with cultural barriers that make it difficult to identify needs, perpetuate the myth that there are no real problems here. This tendency to view the Asian and Pacific Islander community as a "model minority" results in a shortage of funding for necessary programs. Program initiatives targeted for other communities of color are considered inappropriate for Asians and Pacific Islanders; howev-

er, data shortages and the narrow focus of national maternal and child health initiatives on infant mortality make it extremely difficult for advocates within this community to document their grant proposals and petition for services. Those demonstration projects that do exist are temporary; rarely are exemplary strategies and service delivery models incorporated into public health service initiatives.

The federal government should continue to fund demonstration projects tailored to the Asian and Pacific Islander community and should incorporate exemplary models into the public health system.

Effective Outreach. Language barriers often exist between providers and service recipients, and staff who can effectively communicate with clients are not always available. As a result, other staff, such as janitors, sometimes are asked to serve as interpreters; this situation is highly inappropriate in terms of confidentiality, confidence, trust, and medical information.

Even when bilingual staff are available, bicultural staff usually are not. Staff who are sensitive to the cultural diversity of this community are all too scarce. As a result, subtle cultural behaviors and norms are not understood.

Train and certify community outreach workers as a component of providing health care services to the Asian and Pacific Islander community.

Increase Bilingual/Bicultural Professional Staff. Increasing the pool of professionals who not only understand the languages spoken in these communities, but also understand and respect their cultures, would help in reaching populations at risk. One solution might be to encourage health care professionals from this community to return after their training, although the lack of perceived rewards (income, personal satisfaction) makes recruitment difficult. Therefore the group stressed the need for a commitment on the part of all health care professionals, whether or not they are from this community, to provide services in a culturally competent manner as a means of gaining the community's trust. This calls for a sensitivity to the existing beliefs and values of the Asian and Pacific Islander people.

Increase pool of bicultural/bilingual health professionals available to this community,and encourage cultural sensitivity on the part of all health professionals who serve it .

Nctional Advocacy. The Asian and Pacific Islander community lacks a national advocacy group that speaks to their maternal and child health issues and concerns. A national advocacy organization is needed to dispel the myth of model minority, to increase the awareness of this community's diverse subpopulations and their related maternal and child health issues, and to participate in developing national policy.

A national advocacy group for Asians and Pacific Islanders is needed to bring together the very diverse populations that make up this community and serve as a collective voice on maternal and child health issues.

Work group participants included Henrietta Villaescusa, BSN, RN, as group leader, Tanya Pagan Raggio, MD, Carmen de la Cruz Rocco, MD, Jesus Jose (Joe) Rubio, Jr, PhD, and Sylvia Fernandez Villareal, MD.

Overview

The Hispanic/Latino community is heterogeneous: 60.4 percent Mexican American, 12.2 percent Puerto Rican American, 4.7 percent Cuban, 12.3 percent Central and South American (excluding Brazil), and 8.5 percent other, according to 1990 census data. (This breakdown does not include Puerto Ricans living in Puerto Rico.) In total, this community of color accounts for about 10 percent of the U.S. population.

Hispanic/Latino people live predominantly in 10 states throughout the country and are represented in all strata of American society. Most Hispanic/Latinos are bilingual, although some speak only Spanish and still fewer speak only English. An estimated 73 percent of all

Hispanic/Latino persons in the United States were born here. There are thought to be a significant number of undocumented U.S. residents of Hispanic/Latino descent who are undercounted in U.S. census data. Planning services and securing funding for a population which has not been counted is challenging.

The problems surrounding infant and child health within this community are complex. On paper, the statistics seem reassuring in that the infant mortality rate for the Hispanic/Latino community is similar to that for white Americans, despite a greater incidence of risk factors such as poverty and lack of insurance. This has generated interest in looking at the aspects of this culture that play a positive role in birth outcomes. Some observers have suggested that the rise in infant mortality rates among second generation Hispanic/Latino persons may point to a cultural influence that promotes health and diminishes with acculturation.

Some public health experts feel that the Hispanic/Latino infant mortality rate and percentage of low birth weight babies are underestimated, however, since these numbers do not include undocumented, out-of-hospital births and deaths. Also, while the community's infant mortality rates are considered low as a whole, there are higher rates among different subpopulations.

Puerto Rican Americans have the highest infant mortality rate within this group (11.9 per 1000 live births, or 11.9/1000 for the period 1984–86), with low birth weight as a major cause (8). Other problems include high postneonatal mortality and morbidity, low utilization of prenatal services, and high rates of teen pregnancy. The health problems within the Hispanic/Latino community clearly are more serious than what is represented by infant mortality statistics alone. Additional data based on broader health indicators must be collected, and additional health problems, including those extending into childhood and early adulthood, must be addressed.

Points of Discussion

Cultural Strengths and Diversity. The Hispanic/Latino community is both large and extremely complex. It is made up of numerous subpopulations with unique aspects, including language, behaviors, beliefs, and values. The prevailing monolithic approach to delivering health services reflects little understanding and appreciation for this community as a whole, and also fails to recognize the cultural differences that exist between subpopulations and the impact of acculturation within separate subpopulations.

Different levels of acculturation influence approaches to health and nutrition, including reliance on folk medicine. They help shape lifestyle behaviors (including smoking, drinking, use of drugs, reaction to stress), and beliefs, such as spiritualism, Catholicism, or fatalism. These differences, while typically not recognized, all have an impact on health status and behavior. Ironically, even though first generation Hispanic/Latino immigrants tend to be viewed as having poor health habits–a view often associated with low economic status–they probably have better health habits than third or fourth generation immigrants.

Unfortunately, training of health professionals in the United States, with few exceptions, does not include exposure to the Hispanic/Latino culture, and doctors, nurses, and other health care workers from outside the community are ill equipped to overcome problems caused by the language barrier combined with cultural differences. This means that often they are not in a position to utilize the following cultural strengths that were identified by the Hispanic/Latino work group as conducive to promoting good health:

Use of the family model—Family is tremendously important in this culture, and the Hispanic/Latino community is distinguished by the traditional strength of the extended family. This can have a positive influence on health behaviors that affect birth outcomes, including nutrition. It is necessary, therefore, to recognize and honor the social support traditions that sustain families, and for providers to adopt intergenerational approaches that recognize the role that other members of her extended family (eg, mothers, fathers, grandparents, spouses) play in a patient's care.

Traditional medicine—The birth process (and, indeed, the provision of health care overall) has to incorporate traditional practices if providers are to achieve a relationship of trust within this group. Acknowledging traditional practices exhibits one aspect of cultural sensitivity and provides a more complete and comprehensive medical history, while encouraging active participation of the woman in her health care.

When designing models of health care delivery for the Hispanic/Latino community, rely upon recognized cultural strengths of this population.

Data Collection. Inadequate data misrepresent health problems of the Hispanic/Latino community and pose a barrier to obtaining support for improved services. Several factors contribute to this situation.

First, the validity of infant mortality data is skewed by the large number of undocumented members of the community who entered this country without going through immigration channels. Complicating this problem is the fact that cultural norms inhibit the complete reporting of spontaneous abortions and infant deaths. Border populations within this community tend to bury their dead infants in Mexico, where funerals are cheaper than in the United States. This contributes to undercounting, for even when such mothers are not documented, their infants born here are U.S. citizens and therefore their deaths would affect infant mortality rates.

Another data collection problem is the practice of coding Hispanic/Latino persons of fair complexion as white and those with darker complexions as African American. This has been particularly problematic on death certificates, where a significant number of infants have been given an ethnicity different from their parents.

Furthermore, statistical gaps pertaining to maternal and child health data in the Hispanic/Latino community must be filled in. The narrow focus on infant mortality as the primary indicator of maternal and child health means that other important health indicators, such as maternal mortality and child mortality, are missed. Morbidity data, also, have been scarce to nonexistent within the Hispanic/Latino community. Tracking systems are so poor that rates for factors such as birth defects remain virtually unknown.

Broaden health indicators to reflect a more comprehensive view that includes maternal, infant, and child morbidity and mortality, rather than just infant mortality.

Finally, existing data collection methods at the local level do not reflect the complexity of the Hispanic/Latino community. Data collection efforts must begin to segment communities and account for local conditions, including environmental and occupational issues, acculturation, and the various subpopulations that make up these communities.

For a truer picture of the community being served, the work group called for a non-traditional method of data collection. A community survey could be conducted by trained community members in a non-threatening way; this would elicit information from people who are not typically responsive to outsiders. As part of this process, community members should be consulted to assure that the data collected are relevant to their concerns and that culturally appropriate methods are used; it is essential that data reflect the picture of the entire community, including its undocumented members.

Use trained community members to conduct community surveys to obtain data that are more accurate and reflective of the health status of the Hispanic/Latino population.

Empowerment Through Community Base. The Hispanic/Latino community looks to the U.S. public health system to meet its health care needs; however, it views that system as deficient in developing the necessary linkages to provide relevant services and promote health. For the most part, public clinics place no emphasis on community involvement or tailoring services to community needs, even though these are crucial strategies for meeting the needs of this population.

The group recommended that the community be involved in the development of programs under a community-based primary care model. Existing community-based models need to be supported and a mechanism to replicate these models must be instituted. Health care needs must be assessed in a culturally sensitive manner, with community involvement at all levels of planning, development, and implementation. As stated by one group member, "When people are empowered, other things besides health care start to change."

The process of applying for funds is often too cumbersome for community-based organizations for various reasons, including the lack of expertise to successfully apply and obtain support and inadequate manpower to both run the project effectively and maintain funding levels. For this reason the Hispanic/Latino work group recommended that the federal government and others provide the technical assis-

tance, grants, and support needed to build effective community-based models.

They predicted that if community-based primary care and prevention programs are not funded, the cost to the federal government will increase later.

RECOMMENDATION: *Direct federal funding and technical assistance to support the development of effective models for community-based organizations to deliver health care and other service.*

Shortage of Culturally Appropriate Providers. Shortages of culturally competent professionals can be addressed in part through a mechanism targeted to professionals from other countries who have been prevented from practicing in the United States due to various licensing restrictions. A talented pool of Hispanic/Latino health professionals is available, including physicians, health technicians, social workers, nurses, and health educators. Unfortunately, many of these trained professionals are prevented from practicing in the United States due to various licensing restrictions. The group suggested that these providers be actively recruited and assisted with their transition into the U.S. health care system. This might include developing programs to help them prepare for licensing exams in this country and also assisting them with job placement that makes use of their health care skills. These steps broaden access to care for the Hispanic/Latino community and provide a cultural affirmation that is now lacking.

RECOMMENDATION: *Develop programs to recruit and mainstream Hispanic/Latino health care professionals into the U.S. health care system for the specific purpose of providing services to the Hispanic/Latino community.*

In addition, the group noted that Hispanic/Latino youth, for many reasons, do not seek careers as health professionals, and recommended funding for the development or replication of existing mentor programs.

RECOMMENDATION: *Fund and maintain mentor programs that encourage Hispanic/Latino youth to seek careers as health care professionals.*

National Representation. Hispanic/Latino people lack representation in health and social policy formation, both domestically and internationally. Often their concerns with regard to jobs, housing, and other social issues go unheard, even though these factors have a direct impact on the health status of their community.

Another crucial issue is that of funding necessary services to this community based on its actual numbers, for which data are now scarce. Service delivery needs to be rooted in reality, ie, the demand for services should be gauged by the number of people who present for services, and not by the fictional picture presented by statistics.

RECOMMENDATION: *Fund and provide needed services for the Hispanic/Latino community based on demand, regardless of immigration status (ie, documented or undocumented).*

Work group participants included Charon Asetoyer, MA, group leader, Ernest C. Bighorn, Jr, MA, I. Angelina Borbon, RN, Georgia Crawford, BS, and Cynthia A. Smith, MPA.

Overview

Native Americans comprise nearly 1 percent of the U.S. population (0.8 percent). Whether living on or off the reservation, they experience severe maternal and child health problems, even though their infant mortality rate, at 9.7 per one thousand live births (9.7/1000) in 1984–86, was lower than the national average of 10.6/1000. This rate masks substantial differences between Alaskan Natives, whose infant mortality rate was 14.6/1000 in 1985, and American Indians, whose rate was 9.3/1000. Moreover, these data from U.S. Vital Statistics are thought to be underestimated. Results from the 1983 National Birth Cohort Study suggest that the infant mortality rate for Native Americans may be underestimated by as much as 26 percent (9).

Postneonatal deaths are of concern and result from a high incidence of sudden infant death syndrome,* injuries, birth defects, gestational diabetes, and fetal alcohol syndrome. A high adolescent pregnancy rate combined with limited access to and use of prenatal care contribute to large numbers of low birth weight infants.

The Native American group tended to view that community's health problems as directly related to the vestiges of governmental domination, benign neglect and broken promises. Health issues, they felt, must be viewed within the context of cultural, political, economic and spiritual oppression to which tribal nations have been subjected for the past 500 years and to which they continue to be subjected.

Points of Discussion

Barriers to Care. Historically, Native Americans have had a legal right to health care through treaty arrangements with the federal government. Today most Native Americans consider the federal Indian Health Service (IHS) to be their primary health care provider, although these services have not been mandated by Congress as an entitlement program.**

*Sudden infant death syndrome, or SIDS, is the sudden death of an infant under one year of age for which the cause remains unexplained after a complete post-mortem examination, including an investigation of the death scene and review of the case history.

**In legislative terms, an entitlement program is one for which sufficient funding is assured to provide services for all who apply and are deemed eligible.

Within recent years, the IHS has tried to centralize services in locations that are off reservations; as a result, some Native Americans must travel long distances to IHS hospitals or face using more expensive, non-IHS providers. A scaling back of the U.S. Public Health Service Corps has further reduced access to services.

Another concern is that IHS services tend to be crisis-oriented rather than preventive in nature. Native Americans often wait until health conditions have reached life-threatening proportions before seeking care. Services tend to be provided paternalistically, with Native Americans having little or no opportunity to say what care is needed or wanted—as a result they feel they lack choices regarding their own health.

Bring public and private nonprofit health entities together with community groups to develop systems of care that are community based, preventive, and accessible.

Fragmentation and Isolation. The Native American community is extremely isolated, its members out of touch with one another and, particularly for those members living on reservations, with outside communities. The effects

of poverty, geographic isolation, poor transportation, and bureaucratic controls serve to keep interaction to a minimum; this is true both of individuals and organizations representing Native Americans.

Successful strategies are being developed by the Native American community to counteract these effects. Many of these feature community involvement and ownership in new service initiatives–everything from needs assessment to service delivery.

For example, successful nonprofit organizations are focusing on the delivery of community-based, rather than office-based, services. Traditionally, older members of the community have been consulted on the needs of the community, and within the traditional "circle of elders," decisions are reached by consensus.* To replicate this process, community members are being asked for feedback on the relative success of service initiatives and are involved in the decision-making processes of community-based organizations. All segments of the community are becoming involved, from teens to elders.

Integrate into service delivery models strategies that draw from the "circle of elders" concept as well as that of community outreach workers.

Coalition-building is another key strategy. As one example, the Native Women's Reproductive Rights Coalition has developed a broad agenda, addressing such issues as housing,

*A "circle of elders" is defined as a group of older, experienced, respected people within a Native American tribe who serve as guides and decision-makers for the community.

nutrition, domestic violence and assault, diabetes, education, and spiritual and emotional needs. Within coalitions of this sort, real options can be explored by those most affected–including teens, young adults, and the elderly–and efforts made to bridge gaps in communication among different social service providers within a community.

Another strategy being explored at the local level is to train community members as community outreach workers, who then serve as experts and equal members of the health care team. These positions demonstrate an emerging professionalism and are viewed as honorable and respected by the community.

Federal and Tribal Bureaucracy. The bureaucratic entanglements of the Indian Health Service (IHS), the U.S. Public Health Service, the Bureau of Indian Affairs (BIA), and the various tribal governments are a major barrier to access to care and empowerment within this community. The group observed that the IHS, even though it does not take full responsibility for the provision of health services to Native Americans, exerts tremendous control over the availability of resources for community services. And while numerous nonprofit organizations have developed in Native American communities to address unmet needs, these organizations are often thwarted in their attempts to obtain federal and foundation funds.

A significant barrier faced by community-based organizations seeking access to federal, state, and private foundation funding is the need for tribal approval. Because tribal governments are political entities accountable to IHS and/or BIA, community-based organizations often find themselves at odds with these governments in their efforts to secure funding.

Remove political barriers to allow community-based organizations greater access to funding resources.

Data Collection. The practice of combining statistics on many different tribes for data collection purposes seriously distorts the true picture of infant morbidity and mortality within the Native American population. Additionally, Native Americans in urban settings are often miscounted as either Hispanics or whites.

National Representation. Native Americans currently lack opportunities to network and share information about ways of dealing with the deficiencies of their health care system. Their opportunities to participate in national forums addressing maternal and child health issues are limited both by travel restrictions and by lack of access to meetings; as a result, their issues and concerns often go unheard. Greater national representation and involvement will help end the isolation of Native American communities from one another and from other communities of color that face similar challenges.

Representatives from diverse Native American communities, tribes, and nations should be included in and be free to travel to national forums and initiatives concerning maternal and child health.

A SUMMARY

OF ISSUES AND STRATEGIES FOR CHANGE

The diverse nature of the American population requires a reorganization of the current health care system. Understanding the many cultures that are served is not enough. The new and necessary action needed is the acknowledgement that culture and language and lifestyle are the exclusive expertise of the people who live them. The dialogue is between the health care [illegible] culture and the member of the community being served. No one person can be the spokesperson for an ethnic or racial group. In speaking for our people we contribute to the hope that there is a formula or stereotype that can be learned. In fact, each person is an expert on her own life. If we acknowledge this, then we need only be ourselves.

[illegible] Apesteguia

The message of the Roundtable participants, voiced both as members of their respective work groups and collectively, is clear: The existing health care system is not meeting the needs of communities of color and must be significantly changed.

Many of the issues and strategies identified by the work groups were common and recurring and revolve around key themes. They dealt with inadequacies in the current health care system, which the work groups perceived as having particular consequences for communities of color. Among these themes, or inadequacies, are: racism and cultural insensitivity, an overemphasis on the disease model of medical care and neglect of health and wellness concepts, an absence of accurate data collection and analysis, a shortage of needed resources, a crucial need for community empowerment and outreach, and a glaring need for appropriate, culturally sensitive training for health professionals.

Once the system is changed, the chances of correcting such problems as poor birth outcomes and other conditions affecting maternal, infant, and child health will be greatly improved. Six major changes in the system are suggested by the discussions of the work groups; there follows a discussion of each in greater detail.

1. Our health care system must become one that recognizes and respects cultural diversity and provides culturally competent services that are community based.

2. Current methods of data collection and analysis must be assessed and revised to accurately capture problems of maternal, infant, and child health in communities of color.

3. Our existing health care system must shift its medical focus away from the disease model to promotion of health and wellness models of care with respect for traditional health practices.

4. More resources must be made available to expand and continue the Roundtable process and begin developing policy to effect change.

5. Communities of color, all but disenfranchised by the current system, need national representation by organizations willing and able to advocate on their behalf for program and policy expansion.

6. Organizations serving people of color need to be supported by mainstream national organizations in their efforts to develop linkages with one another and build collective support to effect change.

Develop Culturally Competent, Community-Based Systems of Care.
To be truly responsive, the health care system needs to be one that is designed to acknowledge, respect and incorporate the cultures of the populations served. This is best accomplished at the community level, and by providing maximum opportunities for the involvement of local residents. Culturally competent, community- based systems of care will be best able to respond to special needs and concerns as they occur.

The hallmark of such systems would be policies and procedures that were developed by the people served. Eligibility criteria, employment practices, data collection methodologies, even how health professionals are trained—these are all areas subject to resident input, determination and control under a community-based system of care.

Revise Current Methods of Data Collection and Analysis.
Data collection issues were numerous among all of the groups. Issues ranged from presenting data in the aggregate for communities of color, which conceals the true problems that exist within racial and ethnic groups; to limiting the scope of indicators with which we measure and assess problems of maternal, infant, and child health among communities of color; to a lack of community representation in the design of data collection and analysis. Roundtable participants agreed that priorities for communities of color need to include training to develop expertise in research and data collection.

Promote the Health and Wellness Model.
It is clear from the work of the Roundtable that each of these communities of color desires to approach its maternal and child health needs from a health and wellness perspective. Roundtable participants repeatedly expressed support for several concepts. First, they desire that health be viewed in a broader sense, rather than merely as being free from illness, and that the woman be examined in the context of her family, her culture, her community and the larger environment. They desire that health care providers respect and value the role of women as responsible and active participants

in the maintenance of their own health; in this regard, the health professional becomes a facilitator in the natural healing process. Similarly, health care systems should validate and include traditional healers and practices in the maintenance of health and well being, such as homeopathy and midwifery.* Finally, participants recognized that it is important that there be an overall nuturing relationship between the woman and her healer, one that includes commitment, love, caring, and trust.

Provide Resources To Further the Agenda for Communities of Color.

Underlying a majority of the issues raised at the Roundtable is the lack of resources available to address the problems of maternal and infant health in communities of color. These problems and the urgency of developing solutions must be recognized by our leaders and become a national priority, above and beyond the broader interest in health care reform that has already been aroused. The commitment and political will of our leaders must be backed by resources to continue bringing communities of color to the table through the Roundtable process or other mechanisms and together working towards solutions and supporting effective strategies for change.

*Homeopathy is a system of medical practice that treats a disease by the administration of minute doses of a remedy that would, in healthy people, produce symptoms of the disease being treated.

Develop Nationally Based Advocacy Organizations.

Roundtable participants talked about the need for nationally based advocacy organizations devoted to the protection of rights and services for women and children of color. Organizations such as these would help ensure that communities of color are included when determining the agenda and priorities for health care reform. At present, these communities lack the political voice and clout necessary to support the level of change needed to improve maternal, infant, and child health problems in their respective communities.

Develop Linkages Among Communities of Color.

The opportunity to voice concerns, define problems and issues, exchange success stories and build networks and coalitions was welcomed by all Roundtable participants; however, it was clear that more representatives from diverse groups and subpopulations within those groups needed to be heard. It was also viewed as important that the representatives of communities of color have the opportunity not only to come to the table, participate, and be heard, but also that there be an exchange of information among these communities themselves. This would provide each group with a support system and a way to share information which otherwise might not reach them. Examples of such information sharing would include alternative solutions to similar problems and both technical and moral support. Ultimately, these steps will strengthen the Roundtable process from within. Trusting and supportive relationships may be formed that will help empower each of these distinct communities of color to speak in an authentic voice and achieve its unique objectives in maternal, infant, and child health.

■

Get Healthy Mothers, Healthy Babies to listen to what we're in it to serve are our needs and priorities and to buy into our strategies and provide assistance, whether it be financial or material, through tools and equipment.

—Participant, MIPA

■

RECOMMENDATIONS FOR THE HEALTHY MOTHERS, HEALTHY BABIES COALITION

Roundtable participants, both collectively and within cultural work groups, developed recommendations for the national Healthy Mothers, Healthy Babies Coalition (HMHB). Their input was directed towards securing HMHB's help in promoting public awareness, developing networks, distributing public education materials, and developing state coalitions to reduce infant mortality and morbidity. The following recommendations were offered to HMHB coalitions at all levels to support their efforts to work more effectively within communities of color.

- Include diverse community representatives at national, state and local levels. This applies to the different communities of color as well as to subgroups within those communities.
- Advocate and educate within the maternal and child health community on behalf of communities of color.
- Become more visible and interact on a national level on behalf of these communities.
- Collaborate with organizations representing communities of color as a resource and a linkage.
- Become involved on community-based organization boards and disseminate information through these boards.
- Develop a national forum on culturally-specific data collection issues.
- Provide technical assistance to community-based organizations in the area of fund raising and development.
- Increase consumer and health professional awareness of the contributions of midwives and birthing centers in improving health care.
- Assist communities of color in coalition-building efforts and participate in existing community coalitions.
- Ensure that the Roundtable process continues and that even more diverse groups are brought together and are heard.

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Directory of Model Programs

Community Health-In Partnership Services (CHIPS)

2401 N. Grand Avenue, St. Louis, MO 63106 (314)652-9231

CONTACT PERSON: Judy A. Bentley, *Executive Director*

POPULATION SERVED: African American

CHIPS was established to provide health and social service assessments and to manage referrals for comprehensive health services (eg, all medical care, dentistry, and podiatry) for an urban indigent population. An empowerment model is used to overcome barriers and bottlenecks within the health care system; these are negotiated by screening clients to assess their health care needs and by making appropriate referrals to health care providers. Professionals and lay volunteers (CHIPS Reps) work with clients and follow up to make sure they are receiving appropriate care. Prenatal care is delivered by nurse midwives in federally funded community health centers. Women are managed throughout their pregnancies and as long as needed following birth.

Southeast Asian Health Project (SEAHP)

411 East 10th Street, Suite 207, Long Beach, CA 90813 (310) 491-9100

CONTACT PERSON: Lillian S. Lew, *Project Director*

POPULATION SERVED: Southeast Asian

Southeast Asian Health Project is a joint venture of St. Mary Medical Center and United Cambodian Community, Inc., established to empower Southeast Asian refugees to make appropriate choices regarding their own health and well being. Given that fertility rates for Southeast Asian refugees are among the highest in the nation, the primary focus has been the provision of prenatal and maternal health support services. Bilingual workers identify women in need at temples, churches, language and vocational training classes, and through home visits, where prenatal patients are taught hygiene, safety, and nutrition in the context of their own homes. The health educator, with bilingual translators, teaches culturally appropriate health education classes in prenatal nutrition, labor and delivery, breastfeeding, infant feeding, parenting skills, child development, health and hygiene, infant car seat safety, poison prevention and AIDS education. Bilingual outreach workers/translators are used at obstetric clinics and where other medical services are provided. Workshops, conferences and talks are held for health care providers on Southeast Asian healing practices and beliefs.

Sacred Circle of Birth

3124 East 14th Street, Oakland, CA 94601 (510) 261-1962

CONTACT PERSON: I. Angelina Borbon, RN, *Project Director*

POPULATION SERVED: Native American

Sacred Circle of Birth provides community-based comprehensive perinatal services for the Oakland Native American community and promotes the spiritual, physical, and emotional wellness of the Native American family. The best of Western technological medicine is combined with traditional values and practices to strengthen the families of the community by validating their right to traditional, supportive births with dignity. Trusted and respected community members have been trained as community health workers to provide services: a father of three and a mother of five are certified childbirth educators who conduct a childbirth preparation class; over twenty women have been certified as Comadres and can provide support during birth at the hospital; two women are peer breastfeeding counselors; and four have been certified as community outreach workers by a local community college. The program works in partnership with clients and families while focusing on well-documented existing problems such as chemical dependency during pregnancy, and late or no prenatal care.

The Maternity Center Teen Program

Brownsville Community Health Center, 2137 East 22nd Street, Brownsville, TX 78521 (512) 548-7400

CONTACT PERSON: Carmen Rocco, MD, *Medical Director*

POPULATION SERVED: Hispanic/Latino

The Maternity Center of the Brownsville Community Health Center is an out-of-hospital center that emphasizes family centered care and education for its clients. Prenatal, labor and delivery, postpartum, and newborn care to low-risk women is provided by certified nurse midwives with obstetrical and pediatric consultation for problems. Nutrition, laboratory, pharmacy, dental and social services are also provided. Pregnancy outcomes for teenagers are improved through early prenatal care and education. Teens are followed by a multidisciplinary team of case managers, nutritionists, social workers, and nurse midwives, and are encouraged to cooperate and become involved in their own care. The teen case manager is significant in providing a thorough psychosocial assessment of each teen through counseling sessions and home visits; this helps identify areas of needed support requiring networking with other local service agencies. Along with providing comprehensive health services to the pregnant teenager, program goals include increasing the teens well-being during and after pregnancy, improving her self-image and self-care, assisting her in learning parenting skills, encouraging her to continue her education, and providing family planning information and referrals to reduce unintended pregnancies.

The Birthing Project

1810 "S" Street, Sacramento, CA 95814 (916) 442-BABY

CONTACT PERSON: Kathryn Hall, *Executive Director*

POPULATION SERVED: African American

The Birthing Project is a community-based volunteer organization which has established itself as the resource for African American maternal and child health in Sacramento. Building upon the inherent strengths within the African American community (ie, the extended family and the wise woman or "big mamma" concept), the project pairs pregnant women with a support sister who follows them throughout the pregnancy and the first year of the childs life. The women are provided with direction, emotional support, and education to achieve the goal of keeping more babies alive and healthy. Linkages are established to assist women in identifying and obtaining health and human services. On any given day, 200 pairs of women participate in the project.

Native American Women's Health Education Resource Center (NAWHRC)

P.O. Box 572, Lake Andes, SD 57356 (605) 487-7072

CONTACT PERSON: Charon Asetoyer, *Executive Director*

POPULATION SERVED: Yankton Sioux Reservation

The Native American Women's Health Education Resource Center is the first organization of its kind to be located on a reservation. NAWHRC provides health information and referral services to women and a facility where women can address issues of concern to the Native American community, such as education, economic development, and land and water rights. Numerous programs have been developed to deal with women's and children's health issues. Significant among them are programs on AIDS awareness, Native American reproductive rights, fetal alcohol syndrome, nutrition education, ob/gyn self-help, menopause, and child development.

Mary's Center for Maternal and Child Care, Inc.

1844 Columbia Road, NW, Washington, D.C. 20009 (202) 483-8196

CONTACT PERSON: Maria Gomez, *Executive Director*

POPULATION SERVED: Hispanic/Latino

Mary's Center is a prenatal and pediatric center dedicated to increasing access to comprehensive bilingual care for low income, uninsured, pregnant women and their children residing in the District of Columbia. The center is located in the heart of the city's Hispanic/Latino neighborhoods and provides a holistic and culturally-sensitive continuum of care from pregnancy to age 13, including prenatal, intrapartum, delivery, and postpartum care, family planning and primary care, midwifery, and teen parenting services. Mary's Center views pregnancy and childbirth as a healthy natural process—reflecting the cultural traditions of the many Central American immigrants served. Husbands, partners, and families are seen as members of the health care team and are encouraged to become involved. Examples of the centers programs include the Para Ti Project which serves pregnant adolescents and their families through active outreach to local schools and family life education, and First Friends, which has been recognized as a successful resource mother program in the U.S. Commission on Infant Mortality's Report to Congress. In First Friends, trained volunteers are paired with first-time or high-risk pregnant teens or women to provide support through the pregnancy and the baby's first year.

Asian Perinatal Advocates (APA)

1001 Potero Avenue, 6E9, Room 9, San Francisco, CA 94110 (415) 206-5450

CONTACT PERSON: Mai Mai Quon Ho, *Executive Director*

POPULATION SERVED: Chinese, Southeast Asian, and Filipino

Asian Perinatal Advocates is the only hospital-based in-home support program in California specifically serving high-risk Asian newcomers with newborn infants and children up to two years of age. APA's multidisciplinary, bilingual, and bicultural team of paraprofessionals provide on-site and in-home visitation, education and counseling to address problems of child abuse, lack of parenting skills, cultural shock, mental illness and social isolation. Through these efforts to promote infant-parent bonding and to prevent abuse and neglect in Asian families, APA has screened 2700 clients and assisted more than 600 high-risk families over the past four years.

Center for Black Women's Wellness/National Black Women's Health Project

477 Windsor Street, SW, Room 309, Atlanta, GA 30312 (404) 688-9202

CONTACT PERSON: Cheryl Boykins, *Director*

POPULATION SERVED: African American

The Wellness Center is a community-based, self-help facility serving women in three Atlanta housing projects. The Center was established to encourage African American women to be active participants in their health care and their lives in general. It offers adult and teen self-help group development, social service assessments and referrals, and health screenings. Public Housing Outreach was started in 1985 to combat the serious problem of teenage pregnancy. In-home support groups have been formed to encourage girls to postpone bearing children until they are capable of raising them.

The Mom's Project

434 Massachusetts Avenue, G-1, Boston, MA 02118 (617) 534-7411

CONTACT PERSON: Maria Aguiar, *Project Manager*

POPULATION SERVED: African American and Hispanic/Latino

The Mom's project is a community-based project for the prevention of HIV infection and early intervention with women who are using alcohol and other drugs during pregnancy. Women who need services are recruited through street and community-based outreach. Counseling, education, support groups, and immediate assistance are provided to assist women through recovery from addiction, violence and abuse; to enhance and support responsible parenting skills; and to help them obtain needed food, clothing, transportation, and baby-sitting services.

Cherish Our Indian Children Project (COICP)

Healthy Mothers, Healthy Babies, The Montana Coalition

316 Fuller Avenue, P.O. Box 876, Helena, MT 59624 (406) 449-8611

CONTACT PERSON: John Old Elk, *Project Director*

POPULATION SERVED: Native American

Through the Cherish Our Indian Children Project, the Montana HMHB Coalition hopes to reduce the mortality and morbidity rates among Native American infants and children in Montana. To achieve this goal, with a grant from the Kellogg Foundation, the COICP is establishing projects on the seven Indian Reservations in Montana, as well as in the seven urban communities in Montana that have Native American centers. Objectives include training Native Americans in community development and maternal and child health issues, as well as providing comprehensive child and family oriented services. To join, communities must submit an application outlining individual community projects and strategies, as well as detailing a proposal for continued funding after the Kellogg grant subsides. Upon acceptance, the various communities become members of the HMHB coalition and the Task Force.

Some of the Native American tribes involved in the project include: the Blackfeet, Crow, Northern Cheyenne, Salish, Kootenai, Gros Ventre, Assiniboine, Sioux, and Chippewa-Cree.

T.H.E. Clinic for Women, Inc.

3860 West Martin Luther King Boulevard, Los Angeles, CA 90008 (213) 295-6571

CONTACT PERSON: Sylvia Drew Ivie, *Executive Director*

POPULATION SERVED: Asian American, Hispanic/Latino, African American

T.H.E. (To Help Everyone) Clinic was established in 1973 by eight women volunteers to meet the health needs of low-income women in the Los Angeles area. Today, the clinic's mission is to provide quality health services at low cost and raise health awareness by educating people to take an active role in their own care. The clinic emphasizes the need for culturally sensitive care in its staffing, programs, and community goals. Currently it offers programs in family planning services, prenatal care, adult medicine, pediatrics; other features include a colposcopy clinic, early intervention with HIV-positive women at early stages of infection, free clinics, health education, counseling services, and community outreach. Two special programs are targeted directly at communities of color: the Asian Health Project, offering bilingual and bicultural health services to Japanese, Filipino, Thai, Tongan, and Vietnamese immigrants and refugees, and the Latino Health Project, which provides the same kind of services for Latino immigrants and refugees.

Pathways to Understanding: Culturally Sensitive,Coordinated Care for Indian Children with Special Health Needs

Southwest Communication Resources, Inc., P.O. Box 788, Bernalillo, NM 87004 (505) 867-3396

CONTACT PERSON: Randi S. Malach, *Program Coordinator*

POPULATION SERVED: Native American

Pathways to Understanding was created to help improve systems of care for Native American children with special needs so that more services are community-based, family-centered, and culturally sensitive and responsive. The project serves Native American families on the Pueblo reservation and in surrounding communities through a linked, statewide system of case management, as well as through training to increase the effectiveness of health care professionals, and technical assistance to projects serving Native American children in other states.

The Baby Love Program

Wake City Maternal Health Program, Wake City Department of Health

10 Sunnybrook Road, Raleigh, NC 27610 (919) 250-4630

CONTACT PERSON: Dorothy Cilenti, *Maternal Health Director*

POPULATION SERVED: Low Income (90% Medicaid, 60% African American)

The Baby Love Program was established in 1987 to combat North Carolina's high infant mortality rate. The program provides health care and support services for low-income pregnant women and children across the state. The key to the program's success has been Maternity Care Coordinators who are located in virtually all local health departments, community and migrant health centers, and in the Cherokee Health Delivery System. They provide a link between services and act as professional client advocates.

Rural Alabama Pregnancy and Infancy Health Program (RAPIH)

West Alabama Health Services, P.O. Box 711, Eutaw, AL 35462 (205) 372-3674 or (205) 372-3281

CONTACT PERSON: Sandral Hullet, MD, *Medical Director*

Mary Browder, *Maternity Labor Coordinator*

POPULATION SERVED: African American

The Rural Alabama Pregnancy and Infancy Health Program is a home-visiting program for young African American mothers in several of the lowest-income counties of rural western Alabama. Visits are made by a team of women lay helpers who are trained and supported by a supervisor with a background in human development. Program participants receive comprehensive prenatal care and are tracked throughout their pregnancies. The goal of the program is to form a trusting bond that will enable the home visitor to provide emotional support and to encourage the adolescent mother to assume responsibility for her own life.

Childbearing Center of Morris Heights

70 W. Burnside Avenue, Bronx, NY 10453-4015 (212) 716-2229

CONTACT PERSON: Jennifer Dohrn

POPULATION SERVED: African American, Asian American, Hispanic/Latino

The Childbearing Center of Morris Heights was established in 1988 by the Maternity Centers Association through an initial grant from the Kellogg Foundation. The Center offers midwifery as a safe alternative to hospital maternity care in a low-income area of the Bronx. The Center emphasizes individual care and attention in order to ensure a safe and natural birth for the mother and child in a home-like room, without medication, monitors, or doctors. Women have access to a jacuzzi, kitchen, and living area, and family and friends are encouraged to attend and celebrate the miracle of birth. The Center is staffed by registered nurse midwives and social workers. The center also offers prenatal care, nutrition information, support groups, and classes about nutrition, breastfeeding, and teenage pregnancy.

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